



September 27, 2019

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Mail Stop C4-26-05  
Baltimore, MD 21244-1850

**Re: CMS-1715-P – Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2020 [84 Fed. Reg. 40482 (August 14, 2019)]**

Dear Administrator Verma:

We are writing collectively as members of the Patient Quality of Life Coalition, a group of over 40 organizations dedicated to advancing the interests of patients and families facing serious illness, with the overarching goal of providing patients with serious illness greater access to palliative care services. Members represent patients and their caregivers, health professionals, and health care systems.

One of the key priorities of the Coalition is to improve patient access to palliative care. Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis) and can be provided along with curative treatment.<sup>1</sup> The goal is to improve quality of life for both the patient and the family.

Studies show that without palliative care, patients with serious illnesses and their families receive poor-quality medical care that is characterized by inadequately treated symptoms, fragmented care, poor communication with health care providers, and enormous strains on family members or other caregivers.<sup>2,3</sup> By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve both quality of care and quality of life during and after treatment.<sup>4,5</sup> In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.<sup>6</sup> Another study found that the receipt of a palliative care consultation within two days of admission was associated with 22 percent lower costs for patients with certain comorbid conditions.<sup>7</sup> The American Heart Association and American Stroke Association have stated that palliative care can be a helpful complement to current care practices and can improve quality of life for stroke patients,

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<sup>1</sup> Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. *J Clinical Oncol* 2012; 30: 880-887.

<sup>2</sup> Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7; 291(1):88-93.

<sup>3</sup> Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly*. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

<sup>4</sup> Delgado-Guay MO, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 115(2) *Cancer* 437-45 (2009).

<sup>5</sup> Casarett D, et al., Do palliative consultations improve patient outcomes? 56 *J Am Geriatric Soc'y* 593, 597-98 (2008).

<sup>6</sup> Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363:733-742.

<sup>7</sup> May P, et al. Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. *Health Affairs*. January 2016.

caregivers, and providers.<sup>8</sup> Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.<sup>9</sup>

Yet despite the demonstrated benefits of palliative care, there remain millions of Americans who do not access such services. Many of these people are included in the five percent of patients who account for approximately 60 percent of all health care spending – those with multiple chronic conditions and functional limitations who have persistent high costs.<sup>10</sup>

The Coalition appreciates the opportunity to provide comments on the proposed rule to updates to the calendar year (CY) 2020 Medicare Physician Fee Schedule proposed rule.

### **Non-Physician Practitioner Services**

Currently CMS permits a hospice to accept drug orders from a physician or a Nurse Practitioner (NP), subject to state scope of practice requirements and hospice policy. In light of the passage of Section 51006 of the Bipartisan Budget Act, CMS proposes to expand this policy to add PAs to the statutory definition of a hospice attending physician. CMS also proposes that the PA must be the patient's attending physician, and may not have an employment or contractual arrangement with the hospice. CMS also solicits feedback on a number of specific questions about the role of non-physician practitioners (NPPs) in hospice care, including queries about the role of NPPs in delivering hospice care, NPP supervision, and personnel requirements.

CMS also proposes that the statutory physician supervision requirement for PA services would be met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services. CMS notes that PAs are currently required to be supervised by physicians under the "general supervision" standard.

Comment: The Coalition supports the use of interdisciplinary care teams, including in the hospice setting which often requires the support of providers with specialized expertise. Hospice patients can have unique care needs and healthcare providers should be empowered to utilize those practitioners, including physicians and NPPs, who can best provide hospice care in a comprehensive, team-based approach. NPPs are valued members of many hospice and palliative care teams, and will only become more important to ensuring access in the face of a growing workforce shortage of palliative care physicians.<sup>11</sup> We urge CMS to continue to examine ways in which interdisciplinary care teams can be supported and enabled to provide patient care consistent with state law and regulation, including for palliative care delivered outside of the hospice setting.

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<sup>8</sup> Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association <http://circ.ahajournals.org/content/early/2016/08/08/CIR.000000000000438> Aug 16.

<sup>9</sup> Agency for Healthcare Research and Quality: System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction. [www.innovations.ahrq.gov/content.aspx?id=3370](http://www.innovations.ahrq.gov/content.aspx?id=3370).

<sup>10</sup> IOM (Institute of Medicine). 2014. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

<sup>11</sup> Kamal AH, Wolf SP, Myers E, et al. Policy Changes Key to Promoting Sustainability and Growth of the Palliative Care Specialty Workforce. *Health Affairs* 2019;38(6):910-918

Consistent with this position, we also support CMS' proposal to update physician supervision requirements for PA services to be aligned with existing requirements for advanced practice nursing (NP and CNS) services.

### **Evaluation & Management (E/M) Visits**

CMS proposes that, in CY2021, the Agency will adopt the new coding, prefatory language, and interpretive guidance framework adopted by the CPT Editorial Panel<sup>12</sup> for office and outpatient E/M visits (CPT codes 99202 – 99215), as well as adopt the RUC-recommended values for these codes. These proposals would replace certain policies proposed and finalized as part of the CY2019 physician fee schedule rulemaking, for example, CMS' proposal of a new, single blended payment rate for level 2 through 4 codes.

Comment: The Coalition thanks CMS for its careful consideration of this topic, and for relying on input from the provider community, to develop common sense approaches to E/M billing and documentation. The Coalition had been concerned that CMS' prior E/M policies could have dis-incentivized the provision of palliative care because the average palliative care patient requires more time and involvement from a treating provider than would have been reimbursed under a blended payment rate. It is our hope that CMS' new proposals will allow hospice and palliative care services to remain available for patients with serious illness. We thank CMS for taking our concerns into account and revisiting the E/M policy in a thoughtful manner and, in particular, we support CMS' proposals to:

- Adopt the CPT coding, prefatory language, and interpretive guidance framework for office and outpatient E/M visits
- Adopt the RUC recommended values for these codes
- Adopt the CPT-recommended prolonged service code 99XXX for prolonged services on the date of service
- Adopt a simplified and consolidated add-on code for inherent complexity (GPC1X)

However, we have concerns with CMS' proposal to prohibit the use of prolonged service codes CPT 99358 and 99359, which allow for furnishing of prolonged services on a date separate from the E/M visit. The very complex, time-intensive nature of palliative encounters often requires prolonged services on a date that is not the same as the visit, and since CPT 99XXX is only available on the date of the visit, we would request that 99358 and 99359 remain payable for prolonged non-face-to-face services furnished on days before and after the date of service.

### **Chronic Care Management**

CMS proposes a modest increase to the payment for Transitional Care Management (TCM) provided to patients after discharge from an inpatient stay or certain outpatient stays, and to allow TCM to be billed concurrently with other codes. CMS is also proposing a number of modifications to billing for Chronic Care Management (CCM), including new add-on codes for CCM and the potential implementation of certain G codes in 2020. Additionally, CMS proposes a new Principal Care Management (PCM) service, which would reimburse clinicians for providing care to patients with one serious and high risk condition. (The current CCM codes require multiple chronic conditions.) CMS also solicits input on an advance beneficiary consent that would apply across a range of communication-technology based services that CMS finalized last year, including

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<sup>12</sup> American Medical Association: CPT Evaluation and Management. 2019. <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>

virtual check-ins, remote evaluation of pre-recorded patient images or videos, and interprofessional internet consultation services.

Comment: The Coalition strongly supports CMS' ongoing efforts to provide appropriate payment for care management services, including TCM and CCM. As CMS rightly notes in the proposed rule, TCM and CCM services present demonstrable value for patients and the Medicare program. Unfortunately, due to inadequate incentives, some care management services remain underutilized. We urge CMS to continue to innovate in the area of care management, and support CMS' focus herein to appropriately provide for care management services. We especially appreciate CMS listening to feedback our Coalition and others have given regarding patients for whom CCM codes are appropriate, but who do not have multiple chronic conditions. Just one serious illness can require multiple providers and services, and therefore needs care management services. We are hopeful that palliative care providers will be able to use the new PCM code to coordinate palliative care for such patients.

Additionally, in instances where beneficiary consent is required, we support a single advance beneficiary consent that would cover all of the communication technology-based services. We believe these services will be valuable for improving access to care for patients with serious illness and support options that would reduce barriers to furnishing and accessing these services.

### **Conclusion**

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the proposed updates to the Quality Payment Program. If you have any questions, please contact Keysha Brooks-Coley, Executive Director of the Patient Quality of Life Coalition, at 202-661-5720 or [Keysha.Brooks-Coley@cancer.org](mailto:Keysha.Brooks-Coley@cancer.org).

Sincerely,

Alzheimer's Association  
Alzheimer's Impact Movement  
American Academy of Hospice and Palliative Medicine  
American Association of Colleges of Nursing  
American Cancer Society Cancer Action Network  
Association of Oncology Social Work  
Association of Pediatric Hematology/Oncology Nurses  
Cancer Support Community  
Catholic Health Association of the United States  
Center to Advance Palliative Care  
Children's National Hospital  
Coalition for Compassionate Care of California

GO<sub>2</sub> Foundation for Lung Cancer  
Motion Picture & Television Fund  
National Brain Tumor Society  
National Coalition for Hospice and Palliative Care  
National Hospice and Palliative Care Organization  
National Palliative Care Research Center  
National Patient Advocate Foundation  
Pediatric Palliative Care Coalition  
Physician Assistants in Hospice and Palliative Medicine  
ResolutionCare Network  
Supportive Care Coalition  
Trinity Health